APPENDIX F

REPORT OF INVESTIGATION
LINE OF DUTY AND MISCONDUCT STATUS
(AR 600–33 or AFR 35-67)

DATE

1 INVESTIGATION OF ☐ INJURY ☐ DISEASE ☐ DEATH

3 STATUS
a. ☐ REGULAR OR EAD
b. CALLED OR ORDERED TO AD FOR
(1) ☐ MORE THAN 30 DAYS
(2) ☐ 30 DAYS OR LESS
c. ☐ INACTIVE DUTY TRAINING (Type)
d. ☐ SHORT TOUR OF ACTIVE DUTY FOR TRAINING

2 TO: *(Major Army or Air Force Commander)*

4 LAST NAME FIRST NAME - MIDDLE INITIAL | 5. SERVICE NO./SSAN | 6 GRADE

7 ORGANIZATION AND STATION OF INDIVIDUAL

DURATION *(Applies ONLY to 3c and 3d)*

	DATE	HOUR
START		
FINISH		

8 OTHER MILITARY PERSONNEL INVOLVED IN THE SAME INCIDENT (Last Name - First Name - Middle Initial)	SERVICE NUMBER OR SSAN	GRADE	LOD INVESTIGATION MADE YES	NO

9 BASIS FOR FINDINGS *(As determined by investigation)*

a. CIRCUMSTANCES | (1) HOUR | (2) DATE | (3) PLACE

(4) HOW SUSTAINED | b. MEDICAL DIAGNOSIS

c. ☐ WAS ☐ WAS NOT PRESENT FOR DUTY

d. ABSENT ☐ WITH ☐ WITHOUT AUTHORITY

(Do not complete e and f in death cases)
e. INTENTIONAL MISCONDUCT OR NEGLECT ☐ WAS ☐ WAS NOT THE PROXIMATE CAUSE

f. ☐ WAS ☐ WAS NOT MENTALLY SOUND

g. REMARKS

10 FINDINGS *(Do not complete in death cases)*
☐ IN LINE OF DUTY
☐ NOT IN LINE OF DUTY - NOT DUE TO OWN MISCONDUCT
☐ NOT IN LINE OF DUTY - DUE TO OWN MISCONDUCT

ORGANIZATION AND STATION OF INVESTIGATING OFFICER

SIGNATURE AND TYPED NAME OF INVESTIGATING OFFICER

GRADE | BRANCH | SERVICE NO./SSAN

ACTION BY APPOINTING AUTHORITY

HEADQUARTERS | DATE

☐ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME

GRADE | BRANCH | SERVICE NO./SSAN

ACTION BY REVIEWING AUTHORITY

HEADQUARTERS | DATE

☐ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME

GRADE | BRANCH | SERVICE NO./SSAN

FOR ACTION OF OFFICE INDICATED IN ITEM 2

DD FORM 1 OCT 68 261

REPLACES EDITION OF 1 AUG 68 EXISTING SUPPLIES OF WHICH WILL BE USED UNTIL EXHAUSTED

APPENDIX F (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code)

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☐ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL	7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☐ MILITARY

8. HOUR AND DATE ADMITTED	9. HOUR AND DATE EXAMINED

10. DIAGNOSIS AND EXTENT OF ☐ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain)

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☐ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):

b. INDIVIDUAL ☐ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).

c. INJURY OR DISEASE ☐ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.

d. INJURY OR DISEASE ☐ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).

e. CONDITION ☐ DID ☐ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☐ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT ☐ NONE ESTIMATE OF TIME LOSS (Days): ☐ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL	13. BLOOD ALCOHOL TEST MADE ☐ YES ☐ NO	14. NO. OF MG ALCOHOL/100 ML BLOOD

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (how, where, when)

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS ☐ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE	20. HOUR AND DATE OF ABSENCE a. FROM	b. TO

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) ☐ YES ☐ NO

22. INDIVIDUAL WAS ON ☐ ACTIVE DUTY ☐ ACTIVE DUTY FOR TRAINING ☐ INACTIVE DUTY TRAINING	23. HOUR AND DATE OF TRAINING a. BEGAN	b. END

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☐ NO	32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☐ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX F (continued)

_____
(Battalion or Squadron Letterhead)

_____
(date)

SUBJECT: TRAVEL ORDERS AND AUTHORIZATION FOR TREATMENT

TO: MEDICAL TREATMENT FACILITY, ATTN: PATIENT ADMINISTRATION
THE ADJUTANT GENERAL, CALIFORNIA NATIONAL GUARD, ATTN: CAMP-SB
UNITED STATES PROPERTY and FISCAL OFFICER for CALIFORNIA, ATTN: CAUS-TR
TRANSPORTATION OFFICER
Individual Concerned

1. The following member of the California Army National Guard is authorized medical care under the provisions of para 6, NGR 40-3, and para 4-2, AR 40-3 and is ordered to report for treatment as indicated:

_____
(Last Name, First Name, MI., SSN, Rank, Unit, Unit Address and ZIP Code)

Attached to: _____
(Name, Address and ZIP Code of Medical Treatment Facility)

Reporting Date: _____ Period: _____

Purpose: ☐ Treatment ☐ Evaluation ☐ Remedial Surgery ☐ MEB ☐ PEB

Additional instructions: Report to Patient Administration for an appointment in _____ at _____ hours
(Clinic or Room)
(allow 15 minutes for processing).
If desired, Transportation Officer will furnish transportation request and meal tickets. Memorandum copy of transportation request and meal tickets will be forwarded to United States Property and Fiscal Officer for California, Camp San Luis Obispo, CA 93403-8660. Travel of dependents and mileage or monetary allowances are not authorized. Reimbursement for actual expenses is authorized. JTR Vol 1, 6005.

FOR ARNG/ARMY USE

AUTH: ☐ 32 USC 318; 37 USC 204(h) For all injuries incurred in line of duty. Also for diseases incurred in line of duty while under orders not specifying 30 days or less.

☐ 32 USC 319; For diseases incurred in line of duty while under orders specifying 30 days or less. Do not use for diseases incurred during inactive duty training.

Accounting classification: FY 89: Tvl, (Off) 2192060 18-1004 P2U21.1000 (211J,219J) _____ /BF0 S04376; (Enl) 2192060 18-1004 P2U41.1100 (211J,219J) _____ /BF0 S04376. (NOTE: Enter UIC in blank for officer or enlisted accounting classification.)

HOR: _____
FORMAT 445

2. Background and status at time of injury/disease are as follows:

Type duty being performed: ☐ IDT ☐ AT ☐ FTTD ☐ REP TRNG ☐ OTHER

Inclusive dates of training: _____

Location where disease or injury occurred: _____

Date of occurrence: _____ Diagnosis: _____

Line of Duty Status: _____ Events leading to incident: _____

_____

3. Request treatment facility complete CAL ARNG Form 40-6-2. If a DA Form 2173 or CAL ARNG Provisional Form 2173 is inclosed, request Section I of that form also be completed. These two forms should be returned to this headquarters along with any civilian medical bills.

FOR THE COMMANDER:

(Signature and signature block of Adjutant)

CAL ARNG Form 40-6-1 **1 Nov 88** **(Replaces CAL ARNG Form 40-6-1 dated 17 Feb 88)**

APPENDIX F (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below:

(to be completed by unit prior to submission to physician)

Normal military duties for: _____
(Service member's MOS)

Consist of the following _____

_____

I have examined _____ on _____
(Name and SSN) (Date)

Disabled from _____ to _____.
(Date) (Date)

Date expected to return to normal military duty: _____
(without limitation)

Cause of disability: _____
(Final Diagnosis)

Type medical treatment furnished: _____

_____

Nature of healing process (prognosis): _____

_____

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes _____ no _____

This individual (is)* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual (has)* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: _____

Current medical profile:
(by service physician)

P	U	L	H	E	S

_____
(Physician's Signature)

_____
(Date Signed)

_____
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319: 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY: Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 **Replaces CAL ARNG Form 40-6-2 17 Feb 88**

APPENDIX F (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS

ORGANIZATION OR ADDRESS

I, _____, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF _____ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA, FORM 1 JUL 72 2823 SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

APPENDIX F (continued)

STATEMENT *(Continued)*

AFFIDAVIT

_____ HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE _____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____

ORGANIZATION OR ADDRESS

_____

_____

_____

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, 19____

at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT	PAGE OF PAGES

☆ U. S. GPO:1977-0-765-037/68

APPENDIX F (continued)

DISPOSITION FORM

OFFICE SYMBOL OR FILE REFERENCE	SUBJECT
	Request for Approval of Incapacitation Pay for _____

THRU: OTAG
Support Branch

FROM DATE CMT 1

1. Request that incapacitation pay for the above individual be approved for lost civilian time from _____ to _____ and/or lost drill time _____, based on an/a injury/disease incurred in line of duty on
(Drill Dates)
_____ while undergoing _____.
(Date Injury/Disease) (Type of training)

2. The following information and documents are furnished to support this request:

a. A copy of approved LOD.
b. Member is expected to return to normal military duty by _____.
c. A current disability statement/CAL ARNG Form 40-6-2.
d. Employer statement CAL NG Form 37-2E, or self-employment statement CAL NG Form 37-2F.
e. Computation Worksheet CAL NG Form 37-2G. (Section I Only)
f. The member has/has not attended training since his/her disability. If so, the dates and type of training (IDT, ADT, AT, etc.) attended were: _____
_____.
g. Member's MOS/SSI, to include title, at the time of injury or onset of disease: _____. Member's PEBD: _____.
h. Member's current ETS or MRD date: _____.
i. Civilian Occupation: Employed as _____ for _____
(Position) (Firm)
_____. Has/has not returned to work since _____.
(Firm address) (Date)
j. Member returned to military duty on _____ and/or civilian _____
(Date) (Date)
occupation.

3. I certify that the injury/disease cited in the attached LOD determination has in fact incapacitated this individual from performing the normal assigned military duties of the MOS/SSI indicated during the period of this payroll. I further certify that proper verification of lost civilian income is attached.

Encls
as

_____
(Sig Block Cmdr)

CAL NG Form 37-2C (15 Jun 87)

APPENDIX F (continued)

ADAPS PAYROLL CERTIFICATE

NAME: _____ RANK: _____ UNIT: _____

TL NUMBER: _____ ACN: _____ DATE RECEIVED: _____

SSN	PRN	ORDERS NUMBER	ORDERS DATE Y Y M M D D

	START DATE Y Y M M D D	END DATE Y Y M M D D	STATE TAX	ENL BAS	ENLISTED BAS DYS	SBAQ	TVL DAYS
1							
2							
3							
4							

SFD	MILEAGE	VHA		SGLI	OPT	MODE	TDC	SUB

ADDRESS LINE 1 (NUMBER & STREET)

ADDRESS LINE 2 (APARTMENT, SUITE, C/O ETC)

ADDRESS LINE 3 (CITY) STATE ZIP CODE

LEAVE (COMPLETE IF REQUESTING PAYMENT OF ACCRUED LEAVE):

1. _____ DAYS EARNED (_____ TO _____) LESS _____ DAYS TAKEN = ACCRUED LEAVE _____ DAYS
2. DAYS ACCRUED LEAVE PAID SINCE 10 FEB 76 _____ (60 DAYS MAXIMUM)

MISCELLANEOUS ENTITLEMENTS: _____

SUPPLEMENTAL (USE TO CORRECT/CHANGE PAY RECEIVED). STATE PROBLEM, BE CONCISE:

_____

CERTIFICATION OF PERFORMANCE (CHECK ONE):

☐ 1 I certify that I have personal knowledge or I have personally verified the duty requested above has been performed. If the date(s) of performance are different than originally requested, I have entered the correct day(s) of duty and have requested amendment of order.

☐ 2. The individual indicated above has or will report for duty in accordance with competent orders and, upon completion of the duty, is due pay and allowances in the grade and status shown. Any change affecting pay that accrues from this date to the ending date of the duty will be immediately reported to the USPFO Checks for this duty will be delivered to the individual not earlier that the last day of duty by an agent who has knowledge of or has verified performance of the duty.

_____ X _____

DATE OF CERTIFICATION PRINT OR TYPE NAME/SIGNATURE

CHECK ☐ COMMANDING OFFICER ☐ SENIOR SOLDIER PRESENT

CAL ARNG Form 37-9 REV 1 May 87

Original - USPFO
Copy - Unit

Previous Editions will be used until exhausted.

APPENDIX F (continued)

INSTRUCTIONS

NAME, RANK, UNIT	Self explanatory
TL NUMBER	Your transmittal letter number
SSN	Social Security Number
PRN	Payroll Number, i.e., J01
ORDER NUMBER	11-3 code as 011-03 (send two (2) copies)
ORDER DATE	Year-Month-Day (YYMMDD)
TRI START & END DATES	First and last day of duty (YYMMDD), No break in Duty Days.
TR2, 3, & 4	Use only if there are breaks in duty: i.e., on duty weekdays only.
ADDRESS LINES 1, 2, & 3	Self explanatory.

LEAVE

1. Enter number of days earned, beginning and end dates, leave taken (DA 31), and accrued leave.
2. Enter the number of days of accrued leave paid since 10 Feb 76 (see DD Forms 214, PFR etc.).

NOTE: A. Leave may be paid on a supplemental payroll or on the final voucher. In either case, complete 1 & 2 above and attach one copy of all previous DA 2139's and orders to substantiate duty performed.

B. DA 2139's reflecting accrued leave paid should be filed in the permanent section of the PFR (NGB 37-104-3).

MISCELLANEOUS ENTITLEMENTS

Note any entitlements that are not automatically paid, such as: BAQ w/o dependents, enlisted BAS, Saved-pay, VHA and FSA. Payment of enlisted BAS and/or BAQ W/O must be supported by a statement on non-availability in the orders or a DD Form 1351-5 from the duty station. Permission to mess separately may be granted by the unit commander on a DD Form 2496.

SUPPLEMENTALS

1. Supplemental payrolls are used to correct erroneous pay caused by incorrect information received or input by ADAPS. DO NOT use the term "Supplemental" to pay additional duty days as this may delay payment.

2. Send one (1) copy of all supporting documents with your request for supplemental pay. Supporting documents include: all orders, DA Forms 2139 & 3298, federal recognition, etc.

3. Correct payment for BAQ with dependents, promotions, incentive pay and time-in-service depends on information in the SIDPERS data base. It is the unit's responsiblility to telephone SIDPERS to insure that the data base has been corrected before sending the supplemental to ADAPS.

CERTIFICATE OF PERFORMANCE

1. If duty has been performed, check block #1.

2. If duty has started but is not complete, check block #2.

3. An A agent is required if duty has not started. Coordinate with ADAPS.

APPENDIX F (continued)

EMPLOYEE AND EMPLOYER CERTIFICATION

Incapacitation Period _____ To _____

EMPLOYEE

I, _____ _____ hereby authorize the release of
(Typed Name) (SSN)
information requested below, under provision of Title 5, U.S. Code Section 552. This information is required to determine entitlement to Incapacitation Pay from the Federal Government as a result of an injury/disease condition incurred while performing military duty with the Army National Guard. I certify that I received no income from any source, including credit disability insurance, during the incapacitation period above except as follows:

_____

_____.
(If none, so indicate)

x_____ _____
Employee's Signature Date

EMPLOYER

I certify that the above employee has been/was employed by this firm/company from _____ to _____. The last/present position held was _____.

1. Description of duties performed: _____
_____.

2. Did the injury/disease prevent performance of all duties? _____

3. The average gross wages earned immediately before injury/disease was $_____ per _____.

Please attach copies of payroll documents (check stubs, etc.).

a. If seasonal worker, the usual months of employment are _____ to _____.

b. Average number of hours worked per week _____.

c. If paid for overtime, what is the rate and average number of hours worked per week? $_____ _____

d. If other than Monday thru Friday, which days are worked? _____ _____.

CAL ARNG Form 37-2E (1 April 1989) Previous Editions are Obsolete

APPENDIX F (continued)

4. If the employee worked during the incapacitation period shown above, please explain _____.

5. If the employee used sick leave or vacation during any part of the incapacitation period or money was provided by a company income protection plan, what were the dates? _____ What was the amount paid ? $_____

6. Please make any comments or give any information you feel will help in the determination of Incapacitation Pay. _____

_____

_____

_____

Date signed: _____ x_____
(Signature)

_____
(Title/Position)

_____
(Company Name)

_____
(Address)

_____
(Address)

_____
(Area Code - Phone Number)

APPENDIX F (continued)

INCAPACITATION PAYROLL TRANSMITTAL

_____(unit) _____(date)

MEMORANDUM FOR Office of the Adjutant General, ATTN: CAMP-SB, P.O.Box 214405, Sacramento, CA 95821-0405

SUBJECT: Request for Approval of Incapacitation Pay

1. Request incapacitation pay for _____

SSN_____ be approved from _____ to _____

based on an injury/disease incurred on _____

2. Soldier attended training since disability occurred on the following dates: _____

3. Soldier's MOS/SSI and title when disabled._____

_____

4. Enlisted soldier's ETS date: _____

5. Civilian employer (indicate if unemployed):_____

_____Occupation:_____

6. Date returned or expected to return to duty:

Military_____Civilian_____

7. Address to which check is to be mailed:_____

_____

8. I certify that, during the period indicated in 1 above, the incapacitation of this soldier prevented him/her from performing the duties of his/her MOS/SSI . Verification of civilian income earned and/or lost is attached.

X_____
(unit commander)
_____

Encl check list
CAL NG Form 37-2H
CAL NG Form 37-2E/2F
CAL ARNG Form 40-6-2
check stub
DA Form 2173/CAL ARNG Form 2173
CAL NG Form 37-D
orders/training schedule

CAL NG Form 37-2C (1 Jan 90)

APPENDIX F (continued)

SOLDIERS CLAIM FORM Reference CAL ARNG Pam 40-2	NAME:	SSN:

INSTRUCTIONS: All incapacitated soldiers are required to prepare this form monthly. It must be included with each incapacitation payroll submitted for payment. Complete the section that pertains to your case: Section 1. - Employed Section 2. - Unemployed Section 3. - Self-Employed Section 4. - All

SECTION 1. - EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment).

3. My claim is substantiated by the enclosed letter(s) from my employer(s).

4. In addition, I certify that I received $ _____ from an income protectin plan (including sick leave, etc.). NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 2. - UNEMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that I am unemployed at present, without income from any source, including, but not limited to, unemployment compensation, social security, workman's compensation or Veteran's Administration payments. If I become employed, while receiving incapacitation pay, I understand it will be my responsibility to notify my unit and/or commander to ensure military pay and allowances will be reduced by the income being received at that time.

SECTION 3. - SELF-EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment). I received $ _____ in gross income from being self-employed for the period above.

3. I am self-employed and in order to substantiate my claims of lost civilian income for the period cited in paragraph 2 above, I have enclosed a copy of my latest IRS Form 1040 with supporting documents including schedule c.

4. In addition I certify that I received $ _____ from an income protection plan (including sick leave, etc.) NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 4. - ALL CLAIMANTS

1. I further certify that the information which I have provided regarding this claim is correct. I understand that the penalty for knowingly and willfully making a false claim or a false statement in connection with a claim is a fine of up to $10,000 or imprisonment for up to 5 years or both. (18 USC 287, 1001)

2. I hereby waive my VA compensation. DA Form 3053 and VA Form 21-8951 are enclosed.

3. Privacy Act statement is enclosed.

DATE:	SOLDIER'S SIGNATURE

CAL NG Form 37-2H (1 Apr 89)

APPENDIX F (continued)

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS / /	TIME OF DAY ☐ A.M. ☐ P.M.
HOME ADDRESS (Number, Street, City , Zip Code)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)		

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost . You also may consult an attorney.

I gave this form to my employer on (date) _____, 19_____.

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT " until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury / /	Date claim form was provided to employee / /	Date claim form was received / /
Name of Employer		
Signature of Employer/Representative		

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1-90)

STATE FUND COPY

APPENDIX F (continued)

PLEASE TYPE ALL INFORMATION, IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain last copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** P.O. BOX 807 SAN FRANCISCO, CA 94101-0807 Telephone: (415) 565-1344	OSHA Case or File No.

PICA [X][X][X] ELITE [X][X][X] ← TYPEWRITER ALIGNMENT GUIDE → PICA [X][X][X] ELITE [X][X][X]

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. FIRM NAME DIVISION 1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP) 2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP) 3A. LOCATION CODE
4A. NATURE OF BUSINESS e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
4B. TYPE OF EMPLOYER: PRIVATE STATE CITY COUNTY SCHOOL DISTRICT OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME 7. DATE OF BIRTH (MM-DD-YY)
8. HOME ADDRESS (Number and Street, City, ZIP) 8A. PHONE NUMBER
9. SEX: Male Female 10. OCCUPATION (Regular job title, not specific activity at time of injury) 11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED 12A. DATE OF HIRE (MM-DD-YY)
13. HOURS USUALLY WORKED: HOURS PER DAY 13A. DAYS PER WEEK 13B. TOTAL WEEKLY HOURS 13C. Under what class code of your policy were wages assigned?
14. GROSS WAGES/SALARY: PER: HOUR DAY WEEK TWO WEEKS MONTH OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City) 15A. COUNTY 15B. ON EMPLOYER'S PREMISES? YES NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc. 19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
22. DATE OF INJURY OR ILLNESS (MM-DD-YY) 23. TIME OF DAY a.m. p.m. 24. Did employee lose at least one full day's work after the injury? NO YES — Date Last Worked: (MM-DD-YY)
25. HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY) No, still off work Yes, date returned: 26. DID EMPLOYEE DIE? NO YES — Date of Death: (MM-DD-YY)
27. WAS ANOTHER PERSON RESPONSIBLE? NO YES 28. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? NO YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 (REV. 8-88)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.

FORM 5020 (REV. 5) April 1987

APPENDIX G
REFERENCES FOR LINE OF DUTY INVESTIGATIONS INCAPACITATION PAY AND MEDICAL BOARDS

AR 600-8-1	-	Army Casualty and Memorial Affairs and Line of Duty Investigations
AR 40-3	-	Medical, Dental and Veterinary Care
AR 40-501	-	Standards of Medical Fitness
AR 315-381	-	Reserve Components Incapacitation System
AR 635-40	-	Physical Evaluation for Retention, Retirement, or Separation
NGR 600-3	-	Line of Duty Determinations (superseded by AR 600-8-1)
NGR 40-501	-	Medical Examination for Members of the Army National Guard
NGR 40-3	-	Medical Care for Army National Guard members
NGB Pam 37-5	-	Management of Incapacitation Pay and Allowances
DODPM	-	Department of Defense Pay and Entitlements Manual

CAL ARNG Pam 40-2

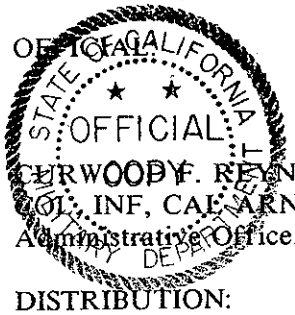
9 July 1990

(CAMP-SB)

BY ORDER OF THE GOVERNOR:

ROBERT C. THRASHER
Major General
The Adjutant General

OFFICIAL:



CURWOOD F. REYNOLDS
COL, INF, CAL ARNG
Administrative Officer

DISTRIBUTION:
A, M